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DEFENSE HEALTH CARE

Reimbursement of Hospitals Not Meeting CHAMPUS Copayment Requirements



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United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

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June 1, 1988

The Honorable Sam Nunn
Chairman, Committee on Armed Services
United States Senate

The Honorable Les Aspin
Chairman, Committee on Armed Services
House of Representatives

This is our report comparing the payment practices of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) for hospitals that do not impose a legal obligation on patients to pay for medical services to the practices of other insurance plans and programs. Our review was required by the National Defense Authorization Act for fiscal years 1988 and 1989.

We are recommending that the Congress enact legislation that would allow hospitals to request that the Secretary of Defense grant a waiver from CHAMPUS copayment requirements and be approved, under certain criteria, to be reimbursed for care to CHAMPUS beneficiaries.

We are sending copies of this report to the Director, Office of Management and Budget; the Department of Defense; and interested congressional committees. We will also provide copies to other parties on request.

A handwritten signature in cursive script that reads 'Lawrence H. Thompson'.

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

For nearly 2 years, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) denied payments totaling about \$615,000 to a heart and lung hospital because it did not bill patients for their shares of the hospital's charges. Although the hospital bills patients' insurance companies and federal health programs, it has a long-standing policy of not billing patients for medical services, regardless of their ability to pay.

The Congress became concerned that CHAMPUS's denial of this hospital's medical claims would unjustly deplete the hospital's endowment and deprive patients of needed medical services. Accordingly, it enacted legislation requiring that in fiscal year 1987, CHAMPUS reimburse the claims of heart and lung hospitals that (1) impose no obligation on patients to pay and (2) receive a specified portion of their operating funds from charitable contributions. Later legislation extended the requirement through fiscal year 1988.

Public Law 100-180, enacted on December 4, 1987, required GAO to review the practices under various insurance plans and federal programs with respect to payments for charges for medical services to hospitals that do not impose a legal obligation on patients to pay for such services. GAO was also required to evaluate CHAMPUS practices regarding such payments and to make recommendations it considered appropriate for changing these practices.

Background

CHAMPUS pays for much of the cost of medical care provided by civilian hospitals, physicians, and other providers to dependents of active-duty service members, retirees and their dependents, and dependents of deceased members of the uniformed services. About 6.2 million persons are eligible as CHAMPUS beneficiaries.

CHAMPUS beneficiaries are required to pay legislatively established deductible and coinsurance amounts (copayments) for services they receive from civilian health care providers. The providers are responsible for collecting the copayments. CHAMPUS does not routinely monitor the collection of these copayments, but when it becomes aware that a provider waives patient copayments, it denies the provider's claim for reimbursement.

In fiscal year 1987, CHAMPUS payments to civilian medical providers totaled about \$2.1 billion, while beneficiaries' cost shares amounted to about \$946 million.

Results in Brief

Each of the 13 private and federally funded or sponsored health benefits plans and programs GAO reviewed had established policies of denying payment to health care providers that do not impose a legal obligation on patients to pay for medical services. In some cases, however, providers impose such obligations and then waive the patients' obligations to pay their shares of the costs of their care. The insurers and programs GAO examined had varied practices regarding reimbursement of providers that waive the patients' shares of medical costs.

Of the plans and programs GAO reviewed, only CHAMPUS and Medicare were aware of dealing with hospitals that did not bill patients for copayments. CHAMPUS denies reimbursement to such hospitals, while Medicare reimburses them. A major concern when a provider waives the patient's copayment is that the provider will increase the amount charged the insurance company to recoup lost revenues. Medicare officials believed that its prospective payment system for hospitals protected the program from paying such increased charges.

Keywords: Civilian Health and Medical Program of the Uniformed Services;

In contrast, all the plans and programs GAO reviewed knew of physicians and other providers who waived copayments and, like CHAMPUS, they were concerned that professional providers could increase their charges to recoup waived copayments. Some reduced the amounts they paid to these providers; others did not. (10T) ↑

GAO identified and analyzed four options for the Congress to consider in dealing with the issue of whether CHAMPUS should reimburse hospitals that do not bill patients for copayments. These options range from permitting the existing legislation to expire at the end of fiscal year 1988 to authorizing the Secretary of Defense to reimburse hospitals that do not bill patients for their copayments if those hospitals meet specified criteria, which could be included in legislation.

GAO believes that hospitals should be required to apply to the Secretary for an exemption from CHAMPUS's copayment requirements and that the Secretary should be required to act on hospitals' applications, using such specified criteria.

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Principal Findings

GAO assessed how CHAMPUS, its beneficiaries, and hospitals would be affected if CHAMPUS were allowed to reimburse hospitals that do not bill patients for copayments.

Potential Effects on CHAMPUS

Without copayments, other controls would need to be in place to help assure that hospitals do not shift the unreimbursed copayments back to CHAMPUS and that overutilization of hospital services does not occur. CHAMPUS's recently instituted prospective payment method with its attendant professional review activities should, if properly implemented, provide such assurance. (See p. 21.)

Potential Effects on Beneficiaries

CHAMPUS reimbursement to hospitals that do not bill patients for copayments would financially benefit beneficiaries since they would not be responsible for paying such copayments. On the other hand, disallowing CHAMPUS reimbursement to such hospitals could decrease beneficiaries' choices of hospitals. Hospitals that do not bill for copayments could also refuse to treat beneficiaries if CHAMPUS did not reimburse them. (See p. 24.)

Potential Effects on Hospitals

Hospitals that do not bill for patient copayments would be relieved of a financial burden of having to fund the total cost of care of CHAMPUS beneficiaries if CHAMPUS were allowed to reimburse these hospitals. The hospital GAO reviewed used its charitable endowment to finance care to CHAMPUS beneficiaries during the period it was denied reimbursement by CHAMPUS. (See p. 25.)

Options Identified

GAO identified four options for dealing with the issue of whether CHAMPUS should reimburse hospitals that do not bill for patient copayments.

1. Allow the exempting legislation to expire. This option would keep in place a control (patient cost sharing) that the health insurance industry has long thought important in helping to contain costs and control overutilization. However, adopting this option might, over time, result in hospitals' refusing to treat CHAMPUS beneficiaries. (See p. 26.)
2. Require CHAMPUS to reduce reimbursements to hospitals that do not bill patients for copayments. This option could help assure that unbilled

patient copayments are not passed on to CHAMPUS. It would, however, reduce CHAMPUS reimbursements to hospitals. (See p. 26.)

3. Make permanent the current legislation exempting certain heart and lung hospitals. This option would continue to allow special treatment for one type of hospital (and possibly only one hospital). Such special treatment raises a concern that other specialty hospitals would seek similar treatment. CHAMPUS officials were concerned that it would erode CHAMPUS's copayment requirements in a piecemeal fashion. (See p. 27.)

4. Broaden current legislation to authorize DOD to exempt hospitals from CHAMPUS copayment requirements based on specified criteria. This option would allow hospitals to request that the Secretary of Defense grant an exemption from CHAMPUS copayment requirements and be approved, under certain criteria, to be reimbursed for care provided to CHAMPUS beneficiaries. GAO discusses the criteria that it believes should, as a minimum, be required to be met by a hospital if it is to be approved for an exemption from CHAMPUS copayment requirements. (See p. 28.)

Recommendation to the Congress

GAO believes that option 4 is the most appropriate of the options identified for dealing with the issue of CHAMPUS reimbursement policy for hospitals that do not bill for patient copayments. Accordingly, GAO recommends that the Congress enact legislation that will authorize, under specified criteria, the Secretary of Defense to use CHAMPUS funds to reimburse hospitals for care provided to CHAMPUS beneficiaries that do not bill patients for copayments. (See p. 29.)

Agency Comments

So that the issues discussed in this report could be available for congressional consideration of Department of Defense authorizing legislation for fiscal year 1989, GAO did not follow its normal practice of obtaining formal comments from the parties whose activities are discussed. GAO did, however, discuss its findings and recommendations with officials in the Office of the Assistant Secretary of Defense (Health Affairs), the Department of Health and Human Services, and the Office of CHAMPUS, and their comments were considered in the preparation of the report. (See p. 29.)

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Appendix

**Appendix I: Suggested Amendment to Title 10, U.S. Code,
Regarding Reimbursement by CHAMPUS to Hospitals
That Do Not Bill Patients for Copayments**

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Abbreviations

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DOD	Department of Defense
DRG	Diagnosis-related group
FEHB	Federal Employees Health Benefits (Program)
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services

Introduction

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) pays for much of the cost of medical care provided by civilian hospitals, physicians, and other civilian providers to dependents of active-duty members, retirees and their dependents, and dependents of deceased members of the uniformed services.¹ The approximately 6.2 million CHAMPUS beneficiaries may also receive medical care on a space-available basis in the 168 military hospitals and hundreds of military clinics worldwide and in the other uniformed services treatment facilities. Under CHAMPUS, beneficiaries must share in the cost of their medical care by paying deductibles and copayments, whereas care in uniformed services facilities is essentially free. In fiscal year 1987, CHAMPUS medical payments totaled about \$2.1 billion, while beneficiaries' cost shares totaled about \$946 million.

The Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) is responsible for program administration. Located at Fitzsimons Army Medical Center near Denver, OCHAMPUS is under the policy guidance and operational direction of the Assistant Secretary of Defense (Health Affairs). OCHAMPUS contracts with private insurance firms, known as fiscal intermediaries, to process medical claims submitted by beneficiaries, hospitals, and professional providers.²

CHAMPUS's Cost-Sharing Requirements

CHAMPUS requires its beneficiaries to share in the costs of care received from civilian providers. This cost-sharing requirement, common in the insurance industry, is intended to discourage beneficiaries from over-using health providers' services and to help control health care costs.

Under CHAMPUS legislation, CHAMPUS beneficiaries are financially liable for specific deductibles and copayments for medical services they receive. For outpatient care, the annual deductible is \$50 per person or \$100 per family. After payment of the deductible, dependents of active-duty members must also pay 20 percent of allowable outpatient charges; all other beneficiaries must pay 25 percent. For inpatient care, dependents of active-duty members pay the greater of \$7.85 per day or \$25 per hospital stay; all others pay a coinsurance amount of 25 percent of professional services plus the lesser of \$175 per day or 25 percent of the

¹The uniformed services include the Army, Navy, Air Force, Marine Corps, Coast Guard, and Commissioned Corps of the Public Health Service and of the National Oceanic and Atmospheric Administration.

²OCHAMPUS reimburses not only hospitals, but also other institutions (such as skilled nursing facilities) as well as professional providers (such as physicians, psychologists, social workers, and dentists).

total hospital bill.³ Beginning in October 1987, beneficiaries' annual copayment liability was capped at \$1,000 for dependents of active-duty members and at \$10,000 for retirees and their dependents.

Methods for Reimbursing Providers Under CHAMPUS

Before October 1987, OCHAMPUS reimbursed hospitals based on the amount of charges billed, a reimbursement method still used by many private health insurance companies as well as health plans under the Federal Employees Health Benefits (FEHB) program. On October 1, 1987, OCHAMPUS implemented a prospective payment system, modeled after Medicare's, whereby it reimburses hospitals preestablished amounts for inpatient care based on the patient's diagnosis. Under this system, hospitals generally must absorb any losses incurred when their actual costs of care exceed the preestablished reimbursement amounts, but may keep any profits realized when their costs are less than the reimbursements. However, OCHAMPUS will adjust its preestablished reimbursement amounts for cases in which the patient's length of stay was unusually short or extremely long and for cases involving extraordinarily high costs compared to those normally required for treatment of a particular diagnosis. OCHAMPUS expects that under the new reimbursement method, the government will save about \$150 million in fiscal year 1988.

CHAMPUS's payment method for professional providers is similar in concept to the "usual, customary, and reasonable charges" method used by other insurance plans and programs. For each procedure or service, CHAMPUS pays the lesser of the provider's billed charge or the established prevailing rate (in the state where the service is provided) for the particular procedure or service. The prevailing rates, which are updated annually, are based on the charges billed by physicians throughout the state over the year. Other insurance plans and federal programs pay the lesser of the provider's billed charge, the provider's customary charge, or the locality's prevailing rate.

Legislation Enacted to Authorize CHAMPUS Payment to Certain Hospitals

In 1983 OCHAMPUS became aware of a heart and lung hospital that did not bill its patients for their shares of the hospital's charges. Instead, the hospital used its charitable endowment to pay the patients' shares. Because the hospital's policy of not billing patients did not meet CHAMPUS cost-sharing requirements, OCHAMPUS denied the hospital's claims for reimbursement. During the 22-month period ended in October 1986,

³Before October 1987, the payment was 25 percent of the hospital bill; the \$175 per day alternative was added when OCHAMPUS initiated a new hospital reimbursement method.

OCHAMPUS denied reimbursement of about \$615,000 to the hospital for medical services provided to CHAMPUS beneficiaries.

The Congress became concerned about the adverse financial impact on the hospital as a result of OCHAMPUS's denial of its medical claims. Accordingly, through a provision in the 1987 Defense Appropriation Act (Public Law 99-500), it authorized OCHAMPUS to exempt certain hospitals from its requirement to deny payment for services for which the patient has no legal obligation to pay. Specifically, the legislation allowed an exemption for heart and lung hospitals that received at least 12 percent of their operating funds from charitable contributions and did not impose a legal obligation on any of their patients to pay for medical services received. This provision allowed CHAMPUS to reimburse the hospital for services provided to CHAMPUS beneficiaries in fiscal year 1987. The Omnibus Budget Reconciliation Act of 1987 (Public Law 100-202) extended this authorization for an additional year and reduced the charitable contribution requirement from 12 to 6 percent.

The number of hospitals that meet the definition in the legislation is unknown. The one hospital that OCHAMPUS had identified as meeting the definition in the legislation routinely bills third-party payers (i.e., insurance companies and federal benefit programs such as Medicare) for their share of the hospital's bills, but it has a long-standing policy of not billing patients, regardless of their ability to pay. Instead, this nonprofit hospital draws upon its charitable endowment to cover the portion that the patient would normally pay. Funded by charitable contributions, the endowment helps to assure that the hospital remains financially viable and that all persons in critical need receive the necessary care.

Objectives, Scope, and Methodology

The National Defense Authorization Act of 1988 and 1989 (Public Law 100-180), enacted on December 4, 1987, required the Comptroller General to

"... review and evaluate the practices under various insurance plans with respect to payments to hospitals for charges for medical services in cases in which the hospital does not impose a legal obligation on patients to pay for such services."

The act required that our review include

- a comparison of CHAMPUS practices regarding such payments with the practices of private sector insurance plans, including self-insured plans,

as well as the practices of federally sponsored or funded programs, including the Medicare, Medicaid, and FEHB programs and an evaluation of whether changes are needed in CHAMPUS practices regarding such payments together with any recommendations considered appropriate and the estimated costs of carrying out such recommendations.

In addition, because of the particular situation regarding the heart and lung hospital discussed on pages 9 and 10, we also reviewed how the various health insurance plans and programs handle situations in which the provider places an obligation to pay on its patients and subsequently waives the amounts not paid by the patients' insurers (i.e., the deductibles and coinsurance).

To evaluate CHAMPUS payment practices, we interviewed OCHAMPUS officials and reviewed CHAMPUS legislation, regulations, and policies concerning beneficiary cost-sharing requirements. We also documented the reasons for OCHAMPUS's denial—for 22 months—of reimbursements to the one hospital that OCHAMPUS officials knew did not bill patients. We visited the hospital, reviewed its policies and billing practices, and interviewed its officials. To determine how the hospital's rates are regulated, we interviewed officials of the state health commission in the state in which the hospital is located. We also interviewed officials of the CHAMPUS fiscal intermediary that processes the hospital's medical claims. We obtained records from the intermediary on reimbursements and denials of this hospital's claims. We also contacted the American Hospital Association in Chicago to identify other hospitals similar to the heart and lung hospital we visited.

To obtain information on private sector insurance plans, including self-insured plans, we identified—with assistance from the National Underwriter Company—the largest group health insurance companies and several large self-insured companies. We selected for review the six largest private group health insurance companies and three large private self-insured companies. For comparability to CHAMPUS, we selected only plans that had copayment requirements. The following companies were included in our review.

**Group Health Insurance
Companies**

Aetna Life Insurance Company
Connecticut General Life Insurance Company
Metropolitan Life Insurance Company
Mutual of Omaha
Prudential Insurance Company of America
The Travelers Insurance Company

Self-Insured Companies

Chrysler Corporation
Dow Chemical Company
Ford Motor Company

Through telephone contact and mailed questionnaires, we obtained information on these companies' copayment requirements, payment practices, and actions taken when a provider does not impose a legal obligation on patients to pay and waives copayments. When possible, we also obtained copies of companies' policies concerning the plan's and the enrollee's copayment responsibilities. The company spokespersons or supervisory managers we contacted told us that the information they furnished represented their companies' official views.

To obtain information on federally funded or sponsored health benefit programs, we contacted representatives of Medicare, Medicaid, and three FEHB plans, all of which had copayment requirements. For information on Medicare and Medicaid copayment policies and payment practices, we interviewed officials of the Health Care Financing Administration (HCFA) at its headquarters in Baltimore and at the Regions 3 and 8 offices in New York and Denver, respectively. We also interviewed officials of the Department of Health and Human Services' (HHS's) Office of the Inspector General, which has been involved in cases regarding Medicare's position on providers who waive patient copayments. Because Medicaid is essentially state-administered, we also interviewed officials of two state Medicaid offices (in Mississippi and Montana).

For the FEHB program, we interviewed officials of the Blue Cross and Blue Shield Association, Aetna Life Insurance Company, and the National League of Postmasters. We obtained and reviewed information on policies and payment practices for the three plans. We also interviewed an official of the Office of Personnel Management responsible for overall guidance, oversight, and contract administration of the FEHB program.

We performed our review from October 1987 through April 1988. We conducted the review in accordance with generally accepted government auditing standards, except that we did not obtain formal comments from the Department of Defense (DOD) and HHS on a draft of this report. Rather than obtaining such comments, we discussed our findings and recommendations with officials in both Departments in order to make the report available for ongoing congressional deliberation of pending DOD authorizing legislation for fiscal year 1989.

How CHAMPUS and Other Insurers Reimburse Providers That Do Not Bill Patients for Medical Services

Each of the health insurance plans and programs we reviewed had established policies of denying payment to health care providers who impose no legal obligation on patients to pay for the medical services they receive. In some cases, however, providers (such as hospitals and physicians) impose such obligations on their patients and then waive the patients' obligations to pay their shares of the costs of their care (that is, the required copayments as stipulated in the insurers' policies or the government's program regulations). As discussed in this chapter, the programs and insurers we reviewed had varied practices regarding reimbursement of providers when the providers, at least in principle, did impose an obligation but, in practice, do not bill patients for their copayment shares of the cost of medical care received.

Of the plans and programs we reviewed, only CHAMPUS and Medicare had any experience with hospitals that simply did not bill patients for copayments. OCHAMPUS denied payments to such hospitals primarily because the hospitals did not meet cost-sharing requirements and because OCHAMPUS officials are concerned that hospitals might pass along the uncollected copayments to CHAMPUS for reimbursement. Medicare, on the other hand, allows reimbursement to such hospitals, and Medicare officials believe that their prospective payment reimbursement system protects the program from paying for waived patient copayments. Lacking direct experience with such a situation, officials of most other plans and programs were uncertain how they would handle claims from hospitals that did not bill patients for their copayments.

In contrast to the situation regarding hospitals, officials of most plans and programs did have experience with professional providers who waived patient copayments, and most were concerned that waivers would result in increased medical charges to their plans and programs. Their concern was based on their payment systems' inability to adequately control the amounts charged by and reimbursed to professional providers.

None of the plans and programs routinely monitored to determine whether providers were billing for and collecting patient copayments. Although one plan had a procedure to determine whether patients were paying their copayments, this procedure applied only to enrollees who elected a particular payment option of this plan. The other plans and programs, including CHAMPUS and Medicare, had only become aware by chance (through provider advertisements or patient notifications) of hospitals or professional providers that did not bill for copayments.

CHAMPUS Denies Reimbursement to Providers That Do Not Impose a Payment Obligation on the Patient

CHAMPUS has two policies affecting reimbursements to providers that do not bill patients for their copayments. The first policy pertains to situations in which the provider does not impose a legal obligation to pay on the patient or for which no charge is made or would be made if the beneficiary were not eligible under CHAMPUS. In such cases, the CHAMPUS regulations prohibit payment for services. The CHAMPUS policy is derived from 10 U.S.C. 1079 and 1086, which require beneficiaries to pay a portion of the charges. The second policy involves providers that establish the patient's liability, but then waive it. In these cases, CHAMPUS policy is to reduce payment by the amount of the beneficiary's liability. However, when a provider has not billed a patient for the copayment, it is often difficult for CHAMPUS to determine whether the provider (1) has not imposed a legal obligation on the patient to pay or (2) has imposed an obligation but waived it. Accordingly, CHAMPUS treats each case of nonbilling as one in which the provider did not impose a payment obligation. CHAMPUS contacts the provider and suggests that the provider bill and collect the required copayment from the patient. If the provider still does not attempt collection of the copayment, OCHAMPUS denies reimbursement of the provider's claims.

OCHAMPUS officials cited the following factors and concerns that led to their decisions to deny reimbursement to the one hospital that was known to waive copayments and then to oppose the proposed legislation that was ultimately included in Public Law 99-500.

- CHAMPUS regulations (derived from CHAMPUS enabling legislation) prohibit payment for services or supplies for which the beneficiary has no legal obligation to pay or for which no charge would be made if the beneficiary were not covered by the program.
- Copayments not only reduce the government's costs, but also discourage patients from overusing medical services.
- Providers who waive copayments might increase their charges to the government to recover the uncollected copayments.
- Allowing certain providers to waive copayments may assist those providers in attracting larger clienteles, thus giving them a competitive advantage over other providers that do require copayments.
- Allowing certain providers to waive copayments would result in program inconsistencies among CHAMPUS beneficiaries.

Medicare Reimburses Hospitals That Waive Copayments

Like CHAMPUS, Medicare has a policy of not reimbursing providers that impose no legal obligation on their patients for their medical care provided.¹ Unlike CHAMPUS, however, it does not deny reimbursement to hospitals or professional providers that waive copayments. Hospitals that have waived Medicare copayments have been identified in at least 11 states. According to Medicare regulations, hospitals have discretion in billing patients for copayments. The Medicare regulations state that a hospital "may charge such individual or other person . . . the amount of any deduction or coinsurance imposed . . . [emphasis added]." Under its prospective payment system (in place since 1983), Medicare reimburses hospitals predetermined amounts, based on patients' diagnoses, for the services provided. The predetermined amounts for each of the diagnosis-related groups (DRGs) were developed based on hospitals' historical costs. According to Medicare officials, hospitals' receipt of predetermined amounts gives them incentives to manage efficiently and to release patients as quickly as medically feasible, rather than unnecessarily delaying their release to increase the reimbursement amounts. In addition, if a hospital can demonstrate that it has attempted to collect the beneficiary's copayment but has been unsuccessful, Medicare will reimburse it an additional amount to cover the uncollected copayment (bad debt). On the other hand, if hospitals have willingly waived, or not attempted to collect, patients' copayments, Medicare will reimburse them for the government's share of their bills but will not reimburse them for the uncollected copayments. Medicare officials believe that the program's prospective payment system protects the government in the event that hospitals attempt to increase their charges to Medicare to cover the patients' shares of the hospitals' costs.

The routine waiver of Medical copayments has been regarded as a violation of the criminal provision of the "Anti-Kickback Statute" (42 U.S.C. 1320a-7b(b)). In pertinent part, that provision prohibits anyone from knowingly and willingly offering payment of any remuneration to a person, directly or indirectly, in cash or in kind, to induce such person to purchase or arrange for purchasing items or services for which payment may be made in whole or in part under Medicare.

The waiving of copayments may be viewed as giving something of value to Medicare beneficiaries as an inducement to them to purchase services at an institution where they will not incur any out-of-pocket expense.

¹ An exception to this policy is made in cases where Indian Health Service hospitals provide services to Medicare and Medicaid beneficiaries.

According to an official in HHS's Office of General Counsel, no U.S. attorney had shown any interest in prosecuting such cases. Therefore, the HHS Inspector General, in 1985, requested authority from the Department of Justice to inform the public that no hospital would be prosecuted under the statute for waiving copayments provided the hospital is reimbursed under the Medicare prospective payment system. The Inspector General said that the practice of hospitals waiving copayments does not result in increased cost to Medicare because of the protection provided by the prospective payment system and the oversight of utilization and quality control organizations.

In its reply, the Department of Justice stated that the wholesale waiver of copayments constituted a technical violation of law and that it was beyond the Department's scope to publicly announce that it would not in any instance prosecute conduct that the Congress had proscribed. The Department suggested that if HHS believed that the waiving of copayments should be allowed, it should seek relief from the Congress.

In the Medicare and Medicaid Patient and Program Protection Act of 1987 (Public Law 100-93, enacted Aug. 18, 1987), the Congress gave the Secretary of HHS authority to exclude from participation in health care programs funded under the Social Security Act any person whom the Secretary determines violated the act's antikickback provision. In addition, the Congress authorized the Secretary to promulgate regulations that will exempt certain payment practices that fall within the broad range of the criminal prohibitions but are essentially innocuous. HHS officials told us that final regulations are to be published by August 1989.

Medicare's position is different for professional providers who waive copayments. Medicare officials are concerned that the payment method for professional providers may not adequately protect the program from waived copayments being passed along to Medicare. Under the payment method, which is based not on historical costs, but on "reasonable, customary, and prevailing charges," professional providers can influence their reimbursement levels by continually increasing their charges. To guard against paying inflated charges, Medicare, when it becomes aware of such situations, reduces its payment to professional providers who waive copayments by an amount roughly equivalent to the required patient copayment. For example, if Medicare allowed payment of \$100 to a professional provider who had waived the beneficiary's required 20-percent copayment (\$20), Medicare would reduce its normal 80-percent reimbursement (\$80) to \$64 (or 80 percent of \$80).

Medicaid's Copayments Are Optional

We also obtained information on Medicaid's reimbursement practices for hospitals that do not bill patients for patient copayments. After evaluating that information, however, we do not believe that Medicaid practices can appropriately be compared with CHAMPUS practices because the requirements for copayments are optional under Medicaid and, when states do impose copayments, the amounts they impose are required by law to be nominal.

Intended to serve low-income people unable to pay for their medical care, Medicaid programs are state-administered under broad federal program guidance. Federal law allows states the option of requiring nominal copayments for any medical services provided. Some state programs require no copayments; others require copayments for services provided by either hospitals, professional providers, or both. As of March 1986, eight states² required copayments ranging from \$2 to \$10 per day for services provided by hospitals. Some of these states also set a maximum amount per admission that Medicaid recipients must pay. Twelve states³ required nominal copayments (for example, \$1) for professional providers' services. HCFA and state officials told us that the collection of recipient copayments is not monitored. They also told us that they are not concerned if providers choose to waive copayments, primarily because Medicaid serves the poor, who often cannot afford even the nominal copayments that some states require.

FEHB Plans

The three FEHB plans we reviewed (Aetna Life Insurance Company, Blue Cross/Blue Shield Association, and the National League of Postmasters Plan) all have policies that, like CHAMPUS's, disallow payment when the beneficiary has no legal obligation to pay or when no charge would be made if the patient had no health insurance coverage. Representatives of these plans told us that their plans had no experience in dealing with situations in which hospitals waived copayments. As a result, they could not tell us with certainty what actions their plans would take if they identified a hospital that waived copayments.

Representatives of two of the three plans said they were not concerned about hospitals increasing their rates to cover waived copayments. They

²Health Care Financing, Program Statistics: Analysis of State Medicaid Program Characteristics, 1986 (U.S. Department of Health and Human Services, Health Care Financing Administration).

³Health Care Financing, Program Statistics: Analysis of State Medicaid Program Characteristics, 1986 (U.S. Department of Health and Human Services, Health Care Financing Administration, Office of the Actuary, Baltimore, Maryland; August 1987).

said they would probably pay their plans' share of charges to hospitals that waive copayments. A Blue Cross/Blue Shield representative said he was not concerned because Blue Cross/Blue Shield typically negotiates with hospitals reimbursement rates that are less than billed charges. Additionally, representatives of both plans said they have a claim-review procedure that they believe would detect any unauthorized or unnecessary medical services that might be provided to make up for the copayment amount that was waived. On the other hand, the representative of the third plan, Aetna, told us that Aetna would probably either reduce or deny payments to a hospital that waived copayments. He said Aetna would probably do so because Aetna pays hospitals' billed charges and thus has little control over the amounts charged.

In contrast to their lack of experience in dealing with institutional providers that waived copayments, all three plans had dealt with professional providers who had waived copayments. Two of the plans (Aetna and Postmasters) reduced their payments to such providers by the amount of the required copayments. The other plan (Blue Cross/Blue Shield) reimbursed the provider the same amount it would have paid had the copayment not been waived. Because all the plans used the "usual, customary, and reasonable charge" payment method for professional providers, plan officials were concerned that professional providers would increase their charges to compensate for the waived copayments.

Private Plans

The nine private plans we contacted generally had policies that, like that of CHAMPUS, disallow payment when the beneficiary has no legal obligation to pay or when no charge would be made if the patient had no health insurance coverage.

None of the nine private-sector insurance plans we contacted had knowingly dealt with hospitals that waived patient copayments. However, like all other programs and plans we reviewed, all of the private plans had dealt with professional providers who waived copayments, and most reduced their payments by the required copayment amount to protect themselves against inflated charges. Most representatives said that, for the same reason, they would probably reduce their payments to hospitals if they identified any that waived copayments.

In cases of copayment waivers, a plan's payment method is the deciding factor in whether plan officials are concerned about paying increased charges. Seven of the nine private plans pay hospitals the charges billed

and, with little control over these charges, the plans' officials are concerned about hospitals increasing their charges to recoup waived copayments. As a result, the plan officials said they would probably reduce payments by the required copayment amount. In contrast, two of the plans (both self-insured companies) negotiate reimbursement rates with hospitals. As a result, these plans' representatives would not anticipate changing their payment method for hospitals that waive copayments.

Each of the nine private plans pay professional providers based on the "usual, customary, and reasonable charges" method. As a result, all of the plan representatives shared a concern about increased charges from professional providers. When private plan officials are aware of professional providers who waive copayments, seven of the nine reduce payments by the copayment amounts; another withholds payment pending the provider's agreement to bill the patient for the copayment; and the remaining one requires a copayment receipt from the enrollee before paying the company's share.

According to plan officials, patient copayment waivers are most common with chiropractors and dentists. Some chiropractors have advertised the waivers to increase their clientele. One of the plans has a standard letter that it sends to such professional providers. The letter states, in part:

"[Our] insurance liability can only be accurately determined when we know the amount a provider has actually charged to the patient. Since your widely circulated advertisement indicates it is your regular business practice to forgive that portion of your fee equal to the coinsurance amounts and/or deductible amounts . . . plan benefits will be calculated on the basis of the reduced charges . . . minus any applicable plan deductible and/or coinsurance."

Potential Effects of CHAMPUS Reimbursing Hospitals That Do Not Bill for Patient Copayments

In assessing the potential effects of CHAMPUS reimbursing hospitals that do not bill for patient copayments, we examined the issue from the standpoint of the program, the beneficiaries, and the hospitals.

Allowing CHAMPUS to reimburse hospitals that do not bill for patient copayments would have implications for CHAMPUS costs and program administration. Beneficiaries could be affected in that the practice might create a financial incentive for them to use hospitals that do not bill for patient copayments. Conversely, hospitals that do not bill for copayments could deny care to CHAMPUS beneficiaries if CHAMPUS denied them reimbursement. Hospitals would benefit if they were to receive CHAMPUS reimbursement because they would not have to fund care to CHAMPUS beneficiaries from other sources.

Effects on CHAMPUS

If CHAMPUS were to reimburse hospitals that do not bill patients for copayments, adequate controls would need to be in place to assure that the patients' share of the costs is not passed on to the program and that overutilization of hospital services does not take place. CHAMPUS recently introduced a prospective payment system for hospitals (see p. 9) that should, if implemented properly, afford the program the necessary assurances. As noted on page 23, reimbursing hospitals that do not bill patients for their copayments should have little effect on program administration.

Controls to Prevent Cost Shifting of Waived Copayments

Like many private and public health insurance plans, CHAMPUS considers copayments to be an effective means of helping to control utilization and costs. Accordingly, if CHAMPUS were authorized to reimburse hospitals that do not bill patients for copayments, controls would be needed to help assure that hospitals do not shift some costs back to CHAMPUS or other federal programs to compensate for lost revenues as a result of patients' not paying the copayments.

CHAMPUS's recently implemented prospective payment system, which is modeled after Medicare's system for reimbursing hospitals, contains certain elements that should help to both control overutilization of program benefits and prevent hospitals from shifting patients' shares of hospital charges to CHAMPUS. Under the prospective payment system, CHAMPUS reimburses hospitals predetermined amounts based on the beneficiaries' diagnoses, and hospitals are generally reimbursed these amounts notwithstanding the costs they incur in treating the beneficiaries.

CHAMPUS has begun to implement an additional element in its prospective payment system to help prevent overutilization of hospital services. As an interim measure, OCHAMPUS awarded a contract in late 1987 for a professional review organization that will review, at hospitals receiving CHAMPUS reimbursements, the appropriateness of patient admissions, lengths of stay, and medical services provided. This organization will begin its reviews for admissions occurring on or after October 1, 1987. On a more permanent basis, by April 1, 1989, OCHAMPUS plans to be using the same 52 professional review organizations used by HHS to review hospital utilization under Medicare.

In commenting on the potential effectiveness of the CHAMPUS prospective payment system with its attendant utilization review, OCHAMPUS officials said that while these controls provided some assurance against cost increases and overutilization, they do not believe they provide full protection. For example, the officials pointed out that while the amounts of reimbursement under the CHAMPUS prospective payment system are to be updated over the next 2 or 3 years using Medicare data on the cost of hospital goods and services, the CHAMPUS DRGs will eventually be recomputed taking into account hospital charges. Also, OCHAMPUS officials cautioned that even if CHAMPUS were adequately protected, hospitals would need to recover lost patient revenue from another source in order to recover their costs, and CHAMPUS does not want to be responsible for cost shifting to other payers.

Cost Control Activities at the Hospital Where CHAMPUS Denied Reimbursement

The hospital we reviewed is in one of the two states in which both CHAMPUS and Medicare have approved the use of state-implemented prospective payment systems for reimbursements to hospitals. This hospital has been reimbursed under the state's system since 1982. The state has a professional review organization that regularly reviews the appropriateness of services provided by this and other hospitals in the state. The state reviews help assure that the hospital's reimbursement levels do not exceed those allowed under Medicare's system, and future reviews will also help assure that the hospital's rates do not exceed those allowed under CHAMPUS. Although the state organization meets Medicare's requirements for a professional review organization, it is different from many other Medicare-contracted review organizations in that it reviews services provided to non-Medicare as well as Medicare patients.

The hospital we reviewed also has a utilization review committee that reviews such medical matters as patient admissions, lengths of stay, and

services provided. This committee's review objectives are to identify unnecessary or inappropriate use of inpatient facilities and services.

Other factors at the hospital we reviewed militate against cost shifting and overutilization. The hospital uses its substantial charitable endowment to cover the revenues it loses by not collecting patient copayments. Therefore, this hospital may be less likely to try to recoup these lost copayment revenues from CHAMPUS than might other hospitals with smaller endowments. Also, because of the specialty care nature of the hospital, the opportunity for patients to overuse services may not be as likely as in nonspecialty hospitals. The hospital has no emergency room and no walk-in workload, and it primarily treats patients referred to it by another institution or physician.

Also, unlike most hospitals, the hospital we reviewed employs its physicians and establishes their charges, which are intended to cover only their salaries. With salaried physicians, there is also less incentive to provide unnecessary services than when the amount of compensation paid to the physician is determined by the extent of services provided.

According to officials of the state rate commission, the hospital's reimbursement rates were allowed to increase by 3.7 percent from 1986 to 1987. In comparison, CHAMPUS's reimbursement rates (when CHAMPUS was still paying hospitals' billed charges) increased on the average by 11.3 percent over the same period. From 1987 to 1988 the hospital's rates were allowed to increase by 4.5 percent. Comparable data do not exist for CHAMPUS because the program implemented its new reimbursement method in October 1987.

Implications for Program Administration

CHAMPUS requires copayments from all of its beneficiaries, although it requires different copayments from different categories of beneficiaries. According to OCHAMPUS officials, reimbursing certain hospitals that do not bill patients for copayments constitutes an exception to this requirement and creates inconsistencies in the administration of the program because some beneficiaries would be required to pay copayments while others would not.

OUCHAMPUS administrative experience in paying hospitals that do not bill patients is very limited. OCHAMPUS does not monitor whether beneficiaries are paying their copayments, so virtually no additional costs resulted from implementing the exception legislation. Officials of the fiscal intermediary that processes the claims of the hospital we reviewed

told us that no additional effort or cost had been incurred due to the copayment exception. The intermediary processed the hospital's claims just as it does those of other providers, paying up to the program's liability. Based on the experience gained in processing claims of this hospital, it does not appear that paying hospitals that do not bill patients would significantly complicate program administration.

OCHAMPUS has dealt with only one hospital that does not bill all patients for their copayment shares—the hospital we reviewed. However, OCHAMPUS officials were aware of other hospitals that did not bill for specific types of services, such as psychiatric and nonsmoking programs. It appears unlikely that many hospitals waive copayments over extended periods and for all patients because of the income that copayments represent.

In a attempt to identify for us the number of hospitals, nationwide, that are not required, under the terms of the exempting legislation,¹ to collect the CHAMPUS patient copayments, the American Hospital Association searched its data base of 5,740 community hospitals. The association's data base did not distinguish between heart and lung hospitals and all other hospitals, nor did it contain information on the level of charitable contributions received by each hospital.

The association's analysis of its data base indicated that the number of hospitals that do not bill their patients is small. The association found only 12 hospitals, including the one we reviewed, that showed no collections from patients and no bad debts, indicating that collections were not attempted. The association qualified this number, stating that it indicates only the number of hospitals that may be waiving patient copayments. Even though the response rates to its annual survey are high, the association's data are limited by what hospitals choose to report. Searching its data base further, the association found that only 2 of the 12 hospitals, including the one we reviewed, reported a high level of unreimbursed charity care; that is, a level greater than the level reported by 75 percent of all hospitals nationwide.

Effects on Beneficiaries

The most obvious effect on beneficiaries of CHAMPUS reimbursing hospitals that do not bill patients is the financial benefit they would gain by not paying copayments for the medical care they receive. On the other

¹Heart and lung hospitals that do not impose on patients an obligation to pay and that receive no less than 6 percent of their funds from charitable contributions.

hand, disallowing payments to such hospitals could restrict beneficiaries' choice in selecting civilian hospitals. If OCHAMPUS denied reimbursement in these cases, the hospitals could deny nonemergency care to CHAMPUS beneficiaries.

The policy at the hospital we reviewed was to provide needed care to all persons, regardless of their ability to pay. Over the long term, however, CHAMPUS beneficiaries could be adversely affected if the hospital were not reimbursed and the financial burden of fully funding beneficiaries' care forced it to deny them services.

Effects on Hospitals

Without CHAMPUS reimbursement, hospitals must either draw on their own resources to pay the full cost of care or refuse treatment to CHAMPUS beneficiaries. Even if hospitals fund beneficiaries' care from their own resources, doing so over the long term could be such a financial burden that it would force hospitals to deny care to CHAMPUS beneficiaries. At the hospital we reviewed, even though CHAMPUS beneficiaries typically make up no more than 1 or 2 percent of the hospital's patient population, the hospital used its charitable endowment to cover the \$615,000 denied by CHAMPUS during a 22-month period.

Also, hospitals that do not bill patients for copayments would be more attractive to beneficiaries than hospitals that require copayments. In the case of the hospital we reviewed, however, patients are generally referred there by other institutions or physicians as opposed to being selected by the patients because the hospital did not bill them for copayments. This hospital provides highly specialized care that is not available in nearby military treatment facilities, and hospital officials told us that it does not advertise that it does not bill patients.

Options for Dealing With CHAMPUS Reimbursement Policies for Hospitals That Do Not Bill Patients

We identified four options for the Congress to consider in dealing with the issue of whether CHAMPUS should reimburse hospitals that do not bill patients for copayments. These options are presented below along with our views concerning their relative merits and drawbacks and information on the costs of each option, to the extent that they can be estimated.

Option 1: Allow the Exempting Legislation to Expire

Retaining the copayment requirement for all hospitals providing care to CHAMPUS beneficiaries, with no exceptions, would keep in place a control that the health insurance industry has long thought important in cost containment and overutilization control. It would also maintain uniformity in program administration. CHAMPUS could avoid payments of about \$200,000 per year—based on OCHAMPUS officials' estimates—by not reimbursing the one hospital that OCHAMPUS knows is not billing patients for their copayments. However, in achieving these cost avoidances, CHAMPUS would be denying payments to a hospital that continues to provide medical care to program beneficiaries. CHAMPUS's estimate assumes that the hospital would continue to provide care to CHAMPUS beneficiaries even while not receiving CHAMPUS reimbursement. However, if beneficiaries went elsewhere for care, the estimated cost avoidances would be reduced, or offset completely by the amount CHAMPUS would pay the other hospitals for the beneficiaries' care.

On the other hand, retaining the copayment requirement may place a financial burden on hospitals that, like the one we reviewed, provide care to CHAMPUS beneficiaries and cover the cost of care from hospital resources when CHAMPUS refuses payment. Over the long term, the requirement could result in hospitals' refusal to treat CHAMPUS beneficiaries, thus limiting their choices of hospitals.

Option 2: Require CHAMPUS to Reduce Its Reimbursements to Hospitals That Do Not Bill Patients for Copayments

Reducing CHAMPUS reimbursements by the amount of the waived copayment is already CHAMPUS policy, but CHAMPUS does not carry out this policy, as discussed in chapter 2. This policy pertains to CHAMPUS's dealing with providers who establish a legal obligation to pay but waive the patients' portions of those obligations. By reducing its reimbursements, CHAMPUS would be following a practice common among many private and federally sponsored or funded plans and programs that reduce reimbursements to professional providers who do not bill patients for copayments. The practice helps assure that the patient's copayment is not passed on to CHAMPUS. However, it is based on the assumption that the provider may increase charges to the insurer to recoup the waived copayment amounts. Where the providers are not increasing their

charges, reducing the reimbursement would unfairly penalize the providers. This option could result in avoidance of CHAMPUS costs of about \$40,000 to \$50,000 a year immediately, based on OCHAMPUS officials' estimate of CHAMPUS reimbursements to the one hospital that does not bill patients for copayments. The estimated cost avoidances would increase to the extent that additional hospitals begin to follow the practice and CHAMPUS becomes aware of it. Savings could disappear if, over time, hospitals not charging CHAMPUS beneficiaries decide not to serve these beneficiaries.

Option 3: Make Permanent the Current Legislation Exempting Certain Heart and Lung Hospitals

This option would benefit the hospital we reviewed by continuing to provide CHAMPUS funds for the medical care provided to CHAMPUS beneficiaries. It would also benefit CHAMPUS beneficiaries, because it would increase their choices of hospitals from which to obtain medical care. This option could also benefit other heart and lung hospitals that meet the legislative requirements. OCHAMPUS officials, however, know of no other hospital that would benefit from this legislation at this time.

Based on an estimate by OCHAMPUS officials, this option would result in reimbursements of \$200,000 per year to the heart and lung hospital we reviewed. However, these reimbursements would be for care provided to CHAMPUS beneficiaries that normally would be paid if it were not for the fact that the hospital did not bill patients for copayments.

Permanently adopting this option would represent a departure from the principle involving the use of copayments as a cost-containment mechanism—a principle considered important in the health care insurance industry. OCHAMPUS officials were concerned about the precedent the option could set for future exemptions of other types of hospitals in that it could erode CHAMPUS copayment requirements in a piecemeal fashion.

A key question concerns the adequacy of controls to prevent cost-shifting and overutilization if CHAMPUS pays hospitals that do not bill patients for their copayments. At the heart and lung hospital we reviewed, multiple controls and unique factors were in place to safeguard CHAMPUS against cost-shifting and overutilization. These include the following: (1) the hospital has been reimbursed since 1982 under a state prospective payment system that has been approved by both Medicare and CHAMPUS; (2) both the hospital and a state organization review patients' utilization of hospital services; (3) the hospital has a substantial charitable endowment to cover amounts not collected for patients; (4) the hospital, as a specialty hospital, receives patients primarily

through referrals from other providers; and (5) the hospital's physicians are salaried by the hospital.

Option 4: Broaden Current Legislation to Authorize DOD to Exempt Hospitals From CHAMPUS Copayment Requirements Based on Specified Criteria

This option would authorize, under specified conditions, CHAMPUS reimbursements to hospitals, in addition to specified heart and lung hospitals, that do not bill patients for their copayments. Under this option, hospitals desiring an exemption from CHAMPUS's copayment requirements would be required to apply to DOD for such an exemption, and the Secretary of Defense or his designee would be authorized to review and either approve or disapprove the hospitals' applications based on established qualification criteria. Broadening the current legislation in this way would obviate the need for the Congress to act each time hospitals seek exemptions from CHAMPUS's copayment requirement.

If the Congress were to enact broadened legislation in this way, the legislation could specify the conditions under which the Secretary or his designee could approve individual exemptions for hospitals from CHAMPUS's copayment requirements. For example, the legislation could require DOD to develop qualifying criteria that hospitals should meet before being granted CHAMPUS reimbursement under an exemption from CHAMPUS's copayment requirements. These criteria should, at a minimum, require that:

- The hospital be certified by a nationally recognized hospital accreditation body (such as the Joint Commission on Accreditation of Healthcare Organizations).
- The hospital would be reimbursed under CHAMPUS's prospective payment system or a CHAMPUS-approved state method.
- The hospital bill CHAMPUS no more than it bills any other payer for comparable services provided.
- The hospital's policy of not billing patients for copayments apply to all patients and all services at that hospital.
- The hospital provide evidence that it has sources of revenue to cover the copayment amounts that will not be billed to the patients.
- The hospital's utilization review committee and a professional review organization regularly review the appropriateness of the hospital's medical services and patient admissions and lengths of stay.

In addition, the legislation should require DOD to periodically review the hospitals it approves for reimbursement under this exemption to assure itself that the hospitals' practices of not billing patients for copayments is not resulting in increased CHAMPUS costs.

Conclusions

In our opinion, the Congress's enactment of legislation specifying the conditions under which DOD is authorized to approve exemptions to its copayment requirements for hospitals (option 4) is the most appropriate of the options discussed above for dealing with this issue. In addition to obviating the need for the Congress to act each time individual hospitals seek exemptions from CHAMPUS copayment requirements, such congressional action would place the responsibility for granting such exemptions on the Secretary of Defense, who would be required to make case-by-case determinations based on specified criteria. Although the number of hospitals that might seek such exemptions is not precisely known, we believe that, under the approval criteria we propose, the likelihood of many hospitals applying for an exemption is low. Also, DOD would be in a position to carefully evaluate hospitals' applications to ensure that its grants of individual exemptions would be in the best interests of the program and its beneficiaries.

Recommendation to the Congress

We recommend that the Congress enact legislation to authorize the Secretary of Defense to use CHAMPUS funds to reimburse hospitals that do not bill patients for copayments. The legislation should require that hospitals seeking such an exemption (1) apply to DOD and (2) as a minimum, meet the exempting criteria discussed on page 28. Suggested legislative language is contained in appendix I.

Agency Comments

So that the issues discussed in this report could be available for consideration by the Congress during the DOD authorization process, we did not follow our normal practice of obtaining formal comments from the parties whose activities are discussed in the report. However, we did discuss the draft report with officials from the Office of the Assistant Secretary of Defense (Health Affairs) and from OCHAMPUS, and their comments were considered in preparation of the report. Portions of the report dealing with Medicare activities were discussed with officials from Medicare and the HHS Inspector General's Office. Their views were also considered when this report was prepared.

Suggested Amendment to Title 10, U.S. Code, Regarding Reimbursement by CHAMPUS to Hospitals That Do Not Bill Patients for Copayments

(a) Section 1079 of Title 10, United States Code, is amended by--

(1) inserting ", except as provided in subsection (m)," after "(a) shall" in subsection (b),

(2) inserting ", except as provided in subsection (m)," after "Members shall" in subsection (e), and

(3) adding at the end the following new subsection:

'(m)(1) The Secretary may, upon request, make payments under this section to hospitals that do not impose a legal obligation on patients to pay their shares of the costs for services if the requesting hospital meets specific criteria established in regulations by the Secretary, including that the requesting hospital --

(1) is certified by a nationally recognized hospital accreditation body,

(2) would be reimbursed under CHAMPUS's prospective payment system or a CHAMPUS-approved state method,

(3) bills CHAMPUS no more than it bills any other payer for comparable services provided,

(4) has a policy of not billing patients for copayments that applies to all patients and all services,

(5) provides evidence that it has sources of revenue to cover the copayment amounts that will not be billed to the patients, and

(6) provides for its utilization review committee and a professional review organization to regularly review the appropriateness of the hospital's medical services and patient admissions and lengths of stay.

'(2) The Secretary of Defense shall periodically review the hospitals it approves for payment under this subsection to assure that the hospitals' practices of not billing patients for copayments is not resulting in increased payment costs.'

(b) Section 1086 of Title 10, United States Code, is amended by--

(1) inserting ", except as provided by subsection (h)," after "title shall" in subsection (b), and

(2) adding at the end the following new subsection:

'(h) The provisions of section 1079 (m) of this title shall apply to a plan covered by this section.'